Warehouse Local 730 Health Fund: Plan E/Active

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2024 – 12/31/2024

Coverage for: Individual + Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-730-2241. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.associated-admin.com or call 1-800-730-2241 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$800** Individual **/$1,600** Family. Balance billing, excluded services, **Preventive care**, and **deductibles** for specific services do not count toward the **deductible**.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there services covered before you meet your deductible?	Yes. **Preventive care and COVID-19 Testing**	This plan covers some items and services even if you haven't met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/. This plan also covers COVID-19 testing with cost-sharing.
Are there other deductibles for specific services?	Yes. **$100 deductible** per hospital confinement. There are no other specific **deductibles**	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. You don't have to meet deductibles for specific services. See chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Medical in-**network**: **$6,250** Individual / **$12,500** Family Prescription Drugs: **$1,100** Individual/ **$2,200** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	**Premiums**, **balance-billing charges**, health care this plan does not cover, and penalties for failure to obtain pre-authorization for services	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, but only in certain circumstances. See www.cignasharedadministration.com	This plan uses a provider network. You will generally pay less if you use a provider in the plan's network. If you use an out-of-network provider, you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). However,

For more information about limitations and exceptions, see the plan or policy document at www.associated-admin.com

	or call 1-800-768-4695 for a list of **network providers**	balance billing will not apply to emergency services, certain services provided by an out-of-network provider at a network facility, and out-of-network services provided without sufficient notice to you. If possible, check with your provider before you obtain services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	After plan pays $35/visit, you pay 20% **coinsurance** of the Maximum Allowed Amount	After plan pays $35/visit, you pay 20% **coinsurance** of the Maximum Allowed Amount	Maximum of 90 visits/year except for **preventive services.**
	Specialist visit	After plan pays $35/ visit, you pay 20% **coinsurance** of the Maximum Allowed Amount	After plan pays $35/ visit, you pay 20% **coinsurance** of the Maximum Allowed Amount	Maximum of 90 visits/year except for **preventive services.**
	Preventive care/screening/ immunization	No charge	No charge	No **deductible** for **in-network/ out-of-network** visits. You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required for outpatient services.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required for outpatient services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycigna.com	Generic drugs	$15.00 **copay** per prescription	$15.00 **copay** per prescription	**Preauthorization** required for prescriptions of more than a 34-day supply or 180 tablets. You are responsible for a **copay** and difference in cost if you elect a name brand drug when a generic option is available. Not covered if Wal-Mart or Sam's Club pharmacies are used.
	Preferred brand drugs	$40.00 **copay** per prescription	$40.00 **copay** per prescription	
	Non-preferred brand drugs	$75.00 **copay** per prescription	$75.00 **copay** per prescription	
	Specialty drugs	$75.00 **copay** per	$75.00 **copay** per	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		prescription	prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required for outpatient services.
	Physician/surgeon fees	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required for outpatient services.
If you need immediate medical attention	Emergency room care	20% **coinsurance** of the Qualifying Payment Amount	20% **coinsurance** of the Qualifying Payment Amount	Expenses must be incurred within 72 hours of accident or illness. Non-Emergency Illness not covered. The Qualifying Payment Amount (QPA) is based on the median of the in-network rates payable for the same or similar service in the same geographic region, adjusted for inflation. You will never be balance billed for treatment of an Emergency Illness, even if an out-of-network provider charges more than the QPA.
	Emergency medical transportation	20% **coinsurance** of the Qualifying Payment Amount	20% **coinsurance** of the Qualifying Payment Amount	You will never be balance billed for treatment of an Emergency Illness, even if an out-of-network provider charges more than the QPA.
	Urgent care	After plan pays $35/ visit, you pay 20% **coinsurance** of the Qualifying Payment Amount	After plan pays $35/visit, you pay 20% **coinsurance** of the Qualifying Payment Amount	You will never be balance billed for treatment of an Emergency Illness, even if an out-of-network provider charges more than the QPA.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** for all admissions or benefits required. **$100 deductible** per confinement. Max/**180 days** inpatient medical, surgical, mental health, substance abuse disorder.
	Physician/surgeon fees	20% **coinsurance** of the Maximum Allowed	20% **coinsurance** of the Maximum Allowed Amount	Maximum of 90 visits/year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Amount		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	After plan pays $35/ visit, you pay 20% **coinsurance** of the Maximum Allowed Amount	After plan pays $35/ visit, you pay 20% **coinsurance** of the Maximum Allowed Amount	Maximum of 90 visits/year.
	Inpatient services	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** for all admissions or benefits required. **$100 deductible** per confinement. Max/**180 days** inpatient medical, surgical, mental health, substance abuse disorder
If you are pregnant	Office visits	Prenatal - No charge/ Postnatal - After plan pays $35/visit, you pay 20% **coinsurance** (of the Maximum Allowed Amount	Prenatal - No charge/ Postnatal - After plan pays $35/visit, you pay 20% **coinsurance** of the Maximum Allowed Amount	Cost Sharing does not apply for **Preventive** prenatal care.
	Childbirth/delivery professional services	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required for hospital admissions. **$100 deductible** per hospital confinement.
	Childbirth/delivery facility services	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required for hospital admissions. **$100 deductible** per hospital confinement.
If you need help recovering or have other special health needs	Home health care	20% **coinsurance** of the Maximum Allowed Amount	20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required.
	Rehabilitation services	Outpatient - 20% **coinsurance** of the Maximum Allowed Amount	Outpatient - 20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required. Preauthorization required after Physical and Occupational therapy max/16 visits per year Preauthorization required after Speech therapy max/26 visits per year for dependents diagnosed with autism.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Outpatient - 20% **coinsurance** of the Maximum Allowed Amount	Outpatient - 20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required.
	Skilled nursing care	Outpatient - 20% **coinsurance** of the Maximum Allowed Amount	Outpatient - 20% **coinsurance** of the Maximum Allowed Amount	**Preauthorization** required.
	Durable medical equipment	20% coinsurance of the Maximum Allowed Amount	Not covered	Must use CareCentrix.
	Hospice services	Inpatient - 20% **coinsurance** plus charges greater than **$3,000**/per period of care. Outpatient - 20% **coinsurance** plus charges greater than **$2,000**/per period of care	Inpatient - 20% **coinsurance** plus charges greater than **$3,000**/per period of care. Outpatient - 20% **coinsurance** plus charges greater than **$2,000**/per period of care	Patient with a life expectancy of six months or less. Certain lifetime limits may apply.
If your child needs dental or eye care	Children's eye exam	$10 **copay**/visit - **in-network provider**	Not covered	Once every 12 months – Group Vision Services.
	Children's glasses	$10 **copay**/visit - **in-network provider**	Not covered	Certain lenses once every 12 months, frames once every 24 months – Group Vision Services.
	Children's dental check-up	No charge - participating **provider**	Not covered	Certain dental procedures are excluded. See benefits guide for details. Dental Health Centers.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery (generally excluded with certain exceptions)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (Frequency limits apply)
- Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at www.associated-admin.com

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery (If deemed medically necessary) • Chiropractic care (Ninth and subsequent visits must be pre-authorized)	• Dental care (Adult) • Hearing aids • Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-730-2241.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-730-2241.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-730-2241.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-730-2241.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$800
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$900
Copayments	$10
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,670**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$800
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$1,000
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$800
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,110**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" above.
The **plan** would be responsible for the other costs of these EXAMPLE covered services.